Benefits Guide 2003

A Publication of the Department of Personnel & Administration

DPA

Overview

This guide and the accompanying materials are provided as an overview of the 2003 group benefit plans offered to State of Colorado employees and their eligible dependents. The group benefit plans include medical, dental, life insurance, Health and/or Dependent Day Care Flexible Spending Accounts, Short-Term Disability, Long-Term Disability, and Tax Deferred Savings plans. These enrollment materials do not constitute a binding contract with employees and/or dependents and the State of Colorado. Every effort was made to ensure the accuracy of the information contained in these materials.

The terms and conditions of the state's group benefit plans are controlled by the group master contracts, plan documents, the State Benefit Plans section of the State Personnel Director's Administrative Procedures, and Employee Benefits Written Directives. In the event of a conflict with federal regulations and state statutes, the governing laws will prevail. A copy of the administrative procedures is maintained and available for review through your agency payroll or personnel administrator.

The plans offered by the state are intended and expected to continue, however, the state reserves the right to discontinue or revise these plans at any time. In addition to this guide, other methods of communication such as memos, meetings, newspaper articles, direct mail and electronic media, are used to help keep you informed. For questions prior to enrolling in any of the state's group benefit plans, contact each carrier directly at the phone number listed in the 2003 Benefit Premium card or consult with your agency payroll or personnel administrator. Once you've enrolled, direct your questions to the appropriate carrier(s).

Review this guide carefully and make benefit decisions to meet your and your family's particular needs.

Fraud

It is unlawful for any employee, employee's dependent(s) or other individual(s) to knowingly and intentionally provide false, incomplete, or misleading facts or information on any benefits enrollment form, affidavit, or other document for the purpose of defrauding or attempting to defraud the State of Colorado with regards to the application or claim for group benefits. Penalties may include imprisonment, fines, denial for or termination of enrollment in any or all of the state's group benefit plans, civil damages, or as provided in regulations, statutes, and written directives.

Warning: If you are insured under a separate group medical insurance policy, you may be subject to coordination of benefits as explained in this booklet.

Table of Contents

Colorado Health Plan Description Forms

HMOs

EPO/PPO

COLORADO HEALTH PLAN DESCRIPTION FORM

Kaiser Permanente HMO
PacifiCare HMO
Rocky Mountain Health Plan HMO
San Luis Valley HMO

Colorado Health Plan Description Form - HMOs

	Kaiser Permanente HMO
This form is not a contract. It is only a summary. The contents of this form are subject to provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Ask your insurer for a copy.	
PART A: TYPE OF COVERAGE	
1. TYPE OF PLAN	Health Maintenance Organization (HMO)
2. OUT-OF-NETWORK CARE COVERED? [1]	Only for emergency care and except as noted.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Denver/Boulder: portions of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld counties within the following zip codes: 80001-7, 80010-22, 80024-28, 80030, 80031, 80033-34, 80036-38, 80040-42, 80044-47, 80102, 80104, 80107, 80110-12, 80116-17, 80120-28, 80131, 80134-35, 80137-38, 80150-51, 80154-55, 80160-63, 80201-12, 80214-37, 80238, 80239, 80241, 80243-44, 80246, 80248-52, 80254-56, 80259, 80260, 80261-66, 80270-71, 80273-75, 80279-81, 80290-95, 80299, 80301-4, 80306-10, 80314, 80321-23, 80328-80329, 80401-3, 80421-22, 80425, 80427, 80433, 80437, 80439, 80452-55, 80457, 80465-66, 80470-71, 80474, 80481, 80501-4, 80510, 80513-14, 80516, 80520, 80530, 80533-34, 80537-40, 80542-44, 80601, 80614, 80621, 80623, 80640, 80642-43, 80651. Colo. Spgs.: portions of Douglas, El Paso, Fremont, Park, Pueblo and Teller counties within the following zip codes: 80106, 80118, 80132-33, 80808-09, 80813-14, 80816-17, 80819-20, 80827, 80829, 80831-33, 80840-41, 80860, 80863-64, 80866, 80901, 80903-22, 80925-26, 80928-37, 80940-47, 80949-50, 80960, 80962, 80970, 80977, 80995, 80997, 81007-08, 81212, 81240.
PART B: SUMMARY OF BENEFITS	
4. ANNUAL DEDUCTIBLE - Individual & family	No deductibles
5. OUT-OF-POCKET MAXIMUM [2] a. Individual b. Family	 $3,000 $6,000
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum
7A. COVERED PROVIDERS	Denver: Colorado Permanente Medical Group, P.C. See Provider Directory for complete list. Call 1-800-632-9700 or (303) 338-3800 for Provider Directory. Colo. Spgs: Kaiser affiliated network of PCPs & specialty physicians. Call 888-681-7878 for Provider Directory.
7B. With respect to network plans, are all of the providers listed in 7A accessible to me through my primary care physician?	Denver: N/A. This is not a network plan. Colo. Spgs: Yes
8. ROUTINE MEDICAL OFFICE VISITS	$30 per visit copay for PCP & $50 per visit copay for specialist
9. PREVENTIVE CARE a. Children services b. Adult services	 $15 per visit copay $15 per visit copay
10. MATERNITY a. Prenatal care b. Delivery & inpatient well baby care	 $15 per visit copay $1,000 copay per admission

Colorado Health Plan Description Form - HMOs

PacifiCare HMO	Rocky Mountain Health Plans HMO	San Luis Valley HMO
This form is not a contract. It is only a summary. The contents of this form are subject to provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Ask your insurer for a copy.		
Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Only for emergency care	Only for emergency & urgent care	Only for emergency & urgent care
Plan is available **only** in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Lincoln, Logan, Morgan, Park, Teller, Washington, Weld	Plan is available in all counties throughout the state.	Plan is available only in the following counties: Alamosa, Conejos, Costilla, Mineral, Rio Grande, and Saguache
No deductibles	$2,000 individual; $6,000 family	None
$2,500 $5,000	$3,000 $6,000 Does not include deductible.	2 X annual premium
No lifetime maximum	No lifetime maximum	No lifetime maximum (see Transplants, Line #24)
4,370 physicians and 39 hospitals in Colo. See provider directory for complete list.	Rocky Mountain HMO Network, Banner Health, & Horizons Behavioral Health. See participating provider directory for a complete list of current provider.	All physicians in the San Luis Valley six-county service area; approximately 1,000 specialty providers in Colorado; 15 Colo. hospitals. See provider directory for complete list.
Yes	Yes, except when PCP belongs to Banner Health Systems.	Yes
$30 per visit copay for PCP and $50 per visit copay for specialist.	Designated PCP: $25 per visit copay, not subject to deductible. Any other participating physician: $50 per visit copay. (See Note 1, pg. 11).	$30 per visit copay-PCP $50 per visit copay-Specialist
a. $30 per visit copay for PCP and $50 per visit copay for specialist. b. $30 per visit copay for PCP and $50 per visit copay for specialist.	a. & b: No copay (100% covered), not subject to deductible.	$30 per visit copay-PCP $50 per visit copay-Specialist
a. $30 per visit copay b. $250 copay per day up to maximum of $1,000 copay per admission	a. No copay (100% covered) not subject to deductible. b. $750 copay per day up to 4 days.	a. $30 per visit copay-PCP; $50 per visit copay-Specialist b. $250 copay per day; maximum $1,000 per admission

Colorado Health Plan Description Form - HMOs

	Kaiser Permanente HMO
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescription	Denver: $15 generic/$40 brand for up to a 60-day supply. For drugs on KP approved list, contact KP Medical Office Pharmacist. Colo. Spgs: $15 generic/$40 brand for 60-day supply. For drugs on KP approved list, contact Colo. Spgs. Customer Service.
12. INPATIENT HOSPITAL	$1,000 copay per admission
13. OUTPATIENT/AMBULATORY SURGERY	$150 per procedure copay
14. LABORATORY & X-RAY	No copay (100% covered)
15. EMERGENCY CARE [3]	$100 per visit copay at a participating emergency room or a non-participating emergency room, waived if admitted as inpatient. Payment of nonplan emergency claims is limited to UCR.
16. AMBULANCE	20% copay up to $500 per trip. Not waived if admitted.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$50 per urgent care visit copay.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE [4]	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE a. Inpatient care b. Outpatient care	a. 50% covered for up to 45 days. b. $30 for 40 visits annually.
20. ALCOHOL & SUBSTANCE ABUSE	Inpatient Medical Detox: $1,000 copay per admission. Inpatient Rehab.: 50% covered for up to 30 days. Outpatient: $30 for 40 visits annually.
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	Inpatient: $1,000 copay per admission. Outpatient: $30 per visit copay, limited to 20 visits per injury or illness.
22. DURABLE MEDICAL EQUIPMENT	No copay (100% covered) limited to $2,000 payment per calendar year. Prosthetic arms & legs covered at 100% with no annual maximum.

Colorado Health Plan Description Form - HMOs

PacifiCare HMO	Rocky Mountain Health Plans HMO	San Luis Valley HMO
$15 formulary generic, $40 formulary brand name, $60 non-formulary. A 90-day supply of formulary maintenance medications available by mail-order for two applicable copays. For information on mail-order drug program or for drugs on our approved formulary list, call Customer Service.	a. Outpatient: (includes insulin) - $10 copay for generic. Member pays full price for brand names utilizing RMHMOs discounts from participating pharmacies. b. Inpatient: Drugs & injectables included in inpatient hospital copay. c. Outpatient & self injectables (except insulin) covered as basic benefit subject to 20% coinsurance. (See Note 2, pg. 11). For drugs on approved list, call customer service at 1-800-346-4643.	$15 copay for generic; $40 copay for formulary brand name & formulary brand name where generic is available; $60 non-formulary brand name where generic is available. Prescriptions are filled at the lesser of a 30-day supply or 100 unit dose. Two copays required for 90-day supply of maintenance drugs through mail order. For drugs on our approved list, contact Customer Service.
$250 copay per day up to maximum of $1,000 copay per admission	$750 copay per day up to 4 days.	$250 copay per day; maximum $1,000 per admission
$125 copay per procedure	$350 per visit copay for outpatient surgery and invasive diagnostic tests.	$200 copay per outpatient ambulatory surgery.
No copay (100% covered); MRI, CT, SPECT and PET Scan $100 copay per procedure (in addition to other applicable copays).	Lab: No copay (100% covered) after deductible. XRAY: $50 copay. MRI/CAT/PET: $150 copay.	No copay (100% covered) for physician ordered services. $100 copay for MRI/CAT/PET.
Emergency room setting inside & outside service area: $100 copay per visit, waived if admitted to a facility.	$100 per visit copay, not subject to deductible, for emergency room or similar facility for in- and out-of-network emergency care (waived if admitted).	$100 copayment per visit (waived if admitted)
$100 copay per episode inside and outside the service area.	$50 copay.	20% copay up to $5,000 per trip. Not waived if admitted, not included in out-of-pocket maximum.
$100 copay in emergency room setting inside and outside the service area; otherwise, $50 copay per visit.	$50 copay per visit, not subject to deductible. Out-of-network urgent care covered only if traveling or temporarily absent from service area. Copays do not apply to out-of-pocket maximum.	$50 copay per visit ($100 if in emergency room)
Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
a. 50% coinsurance per admission coverage for maximum of 45 full days or 90 partial days per calendar year. b. $30 copay for visits 1-5; $50 copay thereafter.	a. $750 per day copay up to 8 days, limited to 45 days or 90 partial days per calendar year. (See Note 1, pg. 11) b. $50 per visit copay, limited to 20 visits or $1,000 payable by plan per calendar year. (See Note 1, pg. 11)	a. 50% covered for up to 45 days. b. $30 copay per visit for first 20 visits, then $40 copay for 21 + visits.
Inpatient: 50% of allowed charges, coverage for maximum of 21 days. Outpatient: $30 copay for visits 1-5; $50 copay per visit thereafter. Limit one course of treatment per contract year, two courses of treatment during member's lifetime.	Inpatient-Rehab: 50% coinsurance of covered expenses, limited to 45 days or 90 partial days per calendar year. Outpatient-Rehab: 50% coinsurance of covered expenses, limited to $500 payable by plan per member per calendar year. Detox: Covered as basic medical benefit, limited to removal of the toxic substances from the body. (See Note 1, pg. 11)	Inpatient: 50% per day copay, limited to 30 full days; two treatments per lifetime. Outpatient: $30 copay per visit for first 20 visits; then $40 copay per visit for 21 + visits. Total combined with mental health benefit.
Physical/Occupational: $30 copay per visit; coverage for maximum of 30 sessions per acute condition. Speech: $30 copay per visit; coverage for maximum of 30 sessions per certain acute conditions.	Inpatient: Included in inpatient hospital copay, limited to 60 days per episode per medical condition. Outpatient: $50 per visit copay, limited to 20 visits per episode per condition per calendar year.. (See Note 1, pg. 11)	$30 per visit copay, limited to 30 visits; per acute episode, per condition. $250 per day inpatient hospital copay, $1,000 maximum per admission.
No copay (100% covered). Maximum of $3,000 per member per contract year, including oxygen. Coverage is limited to certain items. Prosthetic arms & legs covered, you pay 20%.	20% coinsurance of covered expenses, limited to $1,200 per year paid by plan for DME, Disposable Medical Supplies, oxygen, and prosthetics/orthotics combined, except for arm & leg, which have	No copay (100% covered) up to $3,000 per calendar year when medically necessary & preauthorized by plan. (includes oxygen).

Colorado Health Plan Description Form - HMOs

	Kaiser Permanente HMO
22. DURABLE MEDICAL EQUIPMENT (continued)	
23. OXYGEN	Covered at 80%, no limit
24. ORGAN TRANSPLANTS [5]	Inpatient: $1,000 copay per admission Outpatient: $50 per visit copay for specialist
25. HOME HEALTH CARE	No copay (100% covered)
26. HOSPICE CARE	No copay (100% covered)
27. SKILLED NURSING FACILITY CARE	No copay (100% covered) limited to 100 days per calendar year.
28. DENTAL CARE	No dental benefits are available under this medical plan. However, the State of Colorado offers two separate dental plans for eligible employees and dependents. See other enrollment materials.
29. VISION CARE	$30 copay per annual exam.
30. CHIROPRACTIC CARE	$30 copay/20 visits annually.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Infertility Treatment: member pays 50% up to annual out-of-pocket maximum. Infertility drugs not covered. Post-mastectomy breast reconstruction including services to attain breast symmetry, prostheses & services due to complications. Travel Clinic for pre-travel health risk assessments, immunizations & prescriptions. Mail-order Pharmacy Denver: Health education classes including Smoking Cessation, Stress Management, Women's Health & Diet & Nutrition. State offers KP Prevention Plan –most classes offered at no copay. Colo. Spgs. Prevention Classes: Some copays may apply.
PART C: LIMITATIONS & EXCLUSIONS	
32. PERIOD DURING WHICH PREEXISTING CONDITIONS ARE NOT COVERED [6]	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THIS POLICY DEFINE A "PRE-EXISTING CONDITION?"	Not applicable. Plan does not impose limitation periods for pre-existing conditions.

Colorado Health Plan Description Form - HMOs

PacifiCare HMO	Rocky Mountain Health Plans HMO	San Luis Valley HMO
	no limit. Disposable supplies not subject to deductible. Diabetic supplies do not apply to annual limit & are not subject to deductible.	
Covered as durable medical equipment (see #22).	Included in durable medical equipment benefit.	Included in durable medical equipment benefit.
Bone marrow (for certain conditions), cornea, liver (for children) & kidney transplants, & skin grafts are covered based on criteria. Heart, heart-lung, lung, kidney-pancreas, & adult liver transplants are covered based on certain criteria.	a. Inpatient: $750 copay per day up to 4 days. b. Outpatient: $350 outpatient surgical facility copay.	$200 copay per day/maximum $1,000. Cornea, heart, heart-lung, lung, kidney, kidney-pancreas, liver, bone marrow (only for certain medical conditions), peripheral blood stem cell. $250,000 Lifetime Maximum Benefit.
No copay (100% covered)	No copay (100% covered), not subject to deductible.	No copay (100% covered) when authorized
No copay (100% covered)	No copay (100% covered). Respite care is limited to periods of 5 days or less.	No copay (100% covered) when authorized.
No copay (100% covered). Covered up to 30 days per contract year.	$50 per day copay, limited to 100 days per calendar year.	No copay (100% covered) when authorized; limited to 30 days per contract year.
No dental benefits are available under this medical plan. However, the State of Colorado offers two separate dental plans for eligible employees and dependents. See other enrollment materials.	Routine: No coverage. Non-Routine: $25/PCP or $50/specialist per visit copay for repair to sound and natural teeth due to accidental injury (See Note 1, pg. 11). Also see State of Colorado dental plans.	No dental benefits are available under this medical plan. However, the State of Colorado offers two separate dental plans for eligible employees and dependents. See other enrollment materials.
$30 copay per visit; One visit per 12 months.	Annual routine screening: $25 copay. Non-routine: $25 copay per visit to PCP/ $50 copay per visit to specialist for treatment due to injury or eye disease (See Note 1, pg. 11).	$20 per visit copay limited to one visit every 24 months. Hardware not covered.
No coverage.	No coverage	No coverage
Allergy injections, $5 copay; infertility treatment covered at 50%; injectables for home use, $75 copayment; cardiac rehabilitation covered to $1,000 within a 90-day period.	Medically necessary eyeglasses and contacts: 20% coinsurance.	Free child car seat program for expectant mothers who meet eligibility criteria; Smoking cessation program - $150 lifetime benefit; Infertility Services: for diagnosis only. 50% copay up to annual out-of-pocket maximum, then coverage at 100%; Hearing Aides –Covered up to $500 once every three (3) years.
Not applicable. Plan does not impose limitation periods for pre-existing conditions.	Not applicable. Plan does not impose limitation periods for pre-existing conditions.	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
No	No	No
Not applicable. Plan does not impose limitation periods for pre-existing conditions.	Not applicable. Plan does not impose limitation periods for pre-existing conditions.	Not applicable. Plan does not impose limitation periods for pre-existing conditions.

Colorado Health Plan Description Form - HMOs

	Kaiser Permanente HMO
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier. Review them to see if a service or treatment you may need is excluded from the policy.
PART D: USING THE PLAN	
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	Yes
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
39. What is the main customer service number?	Denver: 1-800-632-9700 or 303-338-3800 Colo. Spgs: 1-888-681-7878
40. Whom do I write/call if I have a complaint or want to file a grievance? [7]	Denver: Customer Service Center, 2500 S. Havana Street Aurora, CO 80014 303-338-3800 Colo. Spgs: Colo. Spgs. Customer Service, P.O. Box 378020 Denver, CO 80237-8020 1-888-681-7878
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Denver: Policy Form SA425DEN; Large group Colo. Spgs: Policy Form SA425COS; Large group
PART E: COST AND MEDICAL EXPENDITURES	
43. What is the cost for this plan?	Employee Portion / State Contribution / Full Premium
Employee only	$ 95.14 / $147.86 / $243.00
Employee + 1 dep.	$229.18 / $220.90 / $450.08
Employee + 2 or more dep.	$381.06 / $310.62 / $691.68
PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT	
Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan may request answers to the questions listed below. The request may be made orally or in writing to the plan administrator and shall be answered within five (5) working days of the receipt of the request. • What are the three most frequently used methods of payment for primary care physicians? • What are the three most frequently used methods of payment for physician specialists? • What other financial incentives determine physician payment? • What percentage of total Colorado premiums are spent on health care expenses as distinct from administration and profit?	Customer Service Center 2500 S. Havana St. Aurora, CO 80014 303-338-3800

Colorado Health Plan Description Form - HMOs

PacifiCare HMO	Rocky Mountain Health Plans HMO	San Luis Valley HMO
Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier. Review them to see if a service or treatment you may need is excluded from the policy.	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier. Review them to see if a service or treatment you may need is excluded from the policy.	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier. Review them to see if a service or treatment you may need is excluded from the policy.
Yes	No	Yes
Yes	Yes	Yes
No	No	No
1-800-877-9777	1-800-346-4643	1-800-475-8466 or 1-719-852-4055
PacifiCare of Colo. Member Appeals Team P.O. Box 6770 Englewood, CO 80155 1-800-877-9777	Rocky Mountain Health Plans Member Concerns Coordinator P.O. Box 10600 Grand Junction, CO 81506 1-800-346-4643	Complaint & Grievance Coordinator San Luis Valley HMO, Inc. 700 Main, Ste. 100. Alamosa, CO 81101 1-800-475-8466 or 1-719-589-3696
Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
Policy Form State of Colorado; Large group	Policy form SOCF2000; Large group only	Policy Form SLV/SOC2003 Large group only
Employee Portion / State Contribution / Full Premium $176.26 / $147.86 / $324.12 $414.44 / $220.90 / $635.34 $589.28 / $310.62 / $899.90	Employee Portion / State Contribution / Full Premium $207.02 / $147.86 / $354.88 $475.96 / $220.90 / $696.86 $608.52 / $310.62 / $919.14	Employee Portion / State Contribution / Full Premium $116.86 / $147.86 / $264.72 $295.64 / $220.90 / $516.54 $400.90 / $310.62 / $711.52
PacifiCare of Colo. Member Appeals Team P.O. Box 6770 Englewood, CO 80155 1-800-877-9777	Rocky Mountain Health Plans Member Concerns Coordinator P.O. Box 10600 Grand Junction, CO 81506 1-800-346-4643	Operations Manager San Luis Valley HMO, Inc. 700 Main, Ste. 100 Alamosa, CO 81101 1-800-475-8466 or 1-719-589-3696
	NOTE 1: Copays are not subject to deductible and do not apply toward out-of-pocket maximum. **NOTE 2**: Coinsurance does not apply toward deductible or out-of-pocket maximum.	

Colorado Health Plan Description Form - HMOs

ENDNOTES		
1. "Network" refers to a specified group of physicians, hospital, medical clinics and other health care providers that your plan may require you to use in order to get any coverage at all under the plan, or that the plan may encourage you to use because it pays more of your bill if you use their network providers (i.e., go in-network) that if you don't (i.e., go out-of-network).	2. "Out-of-pocket maximum." The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.	3. "Emergency care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonabley would have believed that an emergency medical condition or life or limb threatening emergency existed.
4. "Biologically based mental illnesses" means schizoprenia, schizo-affective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.	5. "Transplants" will be covered only if they are medically necessary and the facility meets clinical standards for the procedure.	6. "Waiver of pre-existing condition exclusions." State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.
7. "Grievances." Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of these procedures.		

COLORADO HEALTH PLAN DESCRIPTION FORM

Anthem Blue Cross and Blue Shield Centennial PPO Plan
Anthem Blue Cross and Blue Shield Liberty EPO Plan

Colorado Health Plan Description Form - PPO/EPO

Anthem Blue Cross and Blue Shield Centennial PPO Plan

This form is not a contract. It is only a summary. The contents of this form are subject to provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Ask your insurer for a copy.

	In-Network	Out-of-Network
PART A: TYPE OF COVERAGE		
1. TYPE OF PLAN	Preferred Provider Organization (PPO)	
2. OUT-OF-NETWORK CARE COVERED? [1]	Yes, but patient pays more for out-of-network care.	
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado.	
PART B: SUMMARY OF BENEFITS		
4. ANNUAL DEDUCTIBLE a. Individual b. Family	 $2,000 $4,000 for all family members	 $4,000 $8,000 for all family members
5. OUT-OF-POCKET MAXIMUM [2] a. Individual b. Family	$5,000 + deductible individual or $10,000 + deductible family. In-network out-of-pocket maximum is NOT applied towards out-of-network out-of-pocket maximum.	$10,000+deductible individual or $20,000 + deductible family. Out-of-network out-of-pocket maximum is NOT applied towards in-network out-of-pocket maximum.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No Lifetime Maximum	No Lifetime Maximum
7A. COVERED PROVIDERS	PPO Provider Network. See provider directory for complete list.	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all of the providers listed in 7A accessible to me through my primary care physician?	Yes	Not applicable
8. ROUTINE MEDICAL OFFICE VISITS	80% after deductible	60% after deductible
9. PREVENTIVE CARE a. Children services b. Adult services	 80% not subject to deductible (to age 13) 80% after deductible	 60% not subject to deductible (to age 13) 60% after deductible
10. MATERNITY a. Prenatal Care b. Deliver & inpatient well baby care	 80% after deductible 80% after deductible	 60% after deductible 60% after deductible
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescription (For in-network, also see line 31)	Inpatient: 80% after deductible; Outpatient: Tier 1 generic formulary, $15; tier 2 brand formulary, $40; tier 3; nonformulary, $60; tier 4 self-admin. injectibles, 30%; per script. up to a 34-day supply. Mail: Tier 1 generic formulary, $30; tier 2 brand formulary, $100; tier 3 nonformulary, $150; tier 4 self-admin.injectibles, 30%; per script. up to a 90-day supply. For approved drug list, call 800-843-5621. Must use participating pharmacy.	Inpatient: 60% after deductible Outpatient: Not covered Mail Service: Not covered
12. INPATIENT HOSPITAL	80% after deductible	60% after deductible
13. OUTPATIENT/AMBULATORY SURGERY	80% after deductible	60% after deductible
14. LABORATORY & X-RAY	80% after deductible	60% after deductible
15. EMERGENCY CARE [3]	80% after deductible	60% after deductible

Colorado Health Plan Description Form - PPO/EPO

Anthem Blue Cross and Blue Shield Liberty EPO Plan
This form is not a contract. It is only a summary. The contents of this form are subject to provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Ask your insurer for a copy.
In-Network Only (out-of-network care is not covered except as noted)
Preferred Provider Organization (PPO)
Only for emergency care
Plan is available throughout Colorado.
No deductibles No deductibles
$2,000 plus copayments $6,000 aggregate plus copayments
No Lifetime Maximum
Anthem Blue Cross and Blue Shield PPO Provider Network. See provider directory for complete list.
Yes
100% after $50 per office visit copayment
100% after $50 per office visit copayment, includes immunizations (up to age 13) 100% after $50 per office visit copayment for routine exam
100% after $50 per office visit copayment $400 copayment per day for the first five days, then 100% until discharge
Inpatient: Included with inpatient hospital copayment (see line 12) Outpatient: Tier 1 generic formulary, $15; tier 2 brand formulary, $40; tier 3 non-formulary, $60; tier 4 self-administered injectibles, 30%; per prescription at a participating pharmacy up to a 34-day supply. Mail Service: Tier 1 generic formulary, $30; tier 2 brand formulary, $100; tier 3 nonformulary, $150; tier 4 self-administered injectibles, 30%; per prescription up to a 90-day supply. For drugs on our approved list, contact Customer Service at 1-800-843-5621 or 303-831-2384. Covered only when received at a participating pharmacy.
$400 copayment per day for first five days, then 100% until discharge.
100% after $200 per surgery copayment
a. Inpatient: included with inpatient hospital copayment (see line 12) b. Outpatient: $50 per office visit copayment or 20% coinsurance if billed by separate provider of care
100% after $100 emergency room visit copayment (waived if admitted to hospital) in or out-of-network.

Colorado Health Plan Description Form - PPO/EPO

	Anthem Blue Cross and Blue Shield Centennial PPO Plan	
	In-Network	Out-of-Network
16. AMBULANCE	80% after deductible (limited to $350 per trip for ground ambulance and $2,500 per trip for air ambulance).	60% after deductible (limited to $350 per trip for ground ambulance and $2,500 per trip for air ambulance).
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	80% after deductible	60% after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE [4]	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE a. Inpatient care b. Outpatient care	a. 80% after deductible (limited to 45 full or 90 partial days per member per calendar year combined with out-of-network). b. 80% after deductible (limited to 30 visits per member per calendar year combined with out-of-network and line 20 outpatient alcohol and substance abuse, with no less than $1,000 in benefits for mental health care.)	a. 60% after deductible (limited to 45 full or 90 partial days per member per calendar year combined with in-network). b. 60% after deductible (limited to 30 visits per member per calendar year combined with in-network and line 20 outpatient alcohol and substance abuse, with no less than $1,000 in benefits for mental health care.)
20. ALCOHOL & SUBSTANCE ABUSE a. Inpatient care b. Outpatient care	80% after deductible limited to medically necessary care. 80% after deductible (limited to 30 visits per member per calendar year combined with out-of-network and line 19 outpatient mental health care, with no less than $500 in benefits for alcohol abuse and no less than $250 in benefits for substance abuse).	60% after deductible limited to medically necessary care. 60% after deductible (limited to 30 visits per member per calendar year combined with in-network and line 19 outpatient mental health care, with no less than $500 in benefits for alcohol abuse and no less than $250 in benefits for substance abuse).
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	80% after deductible	60% after deductible
22. DURABLE MEDICAL EQUIPMENT	80% after deductible	60% after deductible
23. OXYGEN	80% after deductible	60% after deductible
24. ORGAN TRANSPLANTS [5]	80% after deductible	60% after deductible
25. HOME HEALTH CARE	80% after deductible (up to 60 visits per calendar year combined with out-of-network benefits)	60% after deductible (up to 60 visits per calendar year combined with in-network benefits)
26. HOSPICE CARE a. Inpatient b. Outpatient	 80% after deductible 80% after deductible	 60% after deductible 60% after deductible
27. SKILLED NURSING FACILITY CARE	Not covered	Not covered
28. DENTAL CARE	No dental benefits available under this plan. The state offers separate dental plans. See enrollment materials.	No dental benefits available under this plan. The state offers separate dental plans. See enrollment materials.
29. VISION CARE	80% after deductible, covers eye exam once every 24 consecutive months combined with out-of-network.	60% after deductible, covers eye exam once every 24 consecutive months combined with in-network
30. CHIROPRACTIC CARE	80% after deductible (limited to a maximum payment of $750 per calendar year combined with out-of-network)	60% after deductible (limited to a maximum payment of $750 per calendar year combined with in-network)

Colorado Health Plan Description Form - PPO/EPO

Anthem Blue Cross and Blue Shield Liberty EPO Plan
In-Network Only (out-of-network care is not covered except as noted)
a. Ground: 100% after $200 per trip copayment (maximum benefit of $350 per trip) b. Air: 100% after $500 per trip copayment (maximum benefit of $2,500 per trip)
a. Inpatient: $400 copayment per day for first five days, then 100% until discharge b. Outpatient: $100 after $75 per office visit copayment
Coverage is no less extensive than the coverage provided for any other physical illness.
a. 50% coinsurance per admission (limited to 45 full or 90 partial days per calendar year combined with Alcohol Abuse benefits (line 20) b. 50% coinsurance per visit (limited to 30 visits with no less than $1,000 in benefits per calendar year).
Alcohol Abuse: 50% coinsurance per admission (limited to 45 days per year or 90 partial days per calendar year combined with Mental Health benefits (line 19). Substance abuse: 50% coinsurance per admission (limited to 30 days per calendar year or 60 days per lifetime). Alcohol and Substance Abuse: 50% coinsurance per visit (limited to 20 visits with no less than $500 in benefits per calendar year for alcohol abuse; limited to 15 visits per calendar year for substance abuse).
Inpatient: Included with inpatient hospital copayment (see line 12) Outpatient: 100% after $50 per office visit copayment (limited to 20 visits per calendar year; for children limited to 20 therapy visits per calendar year each for physical, occupational and speech therapy up to age 5).
Inpatient: Included with inpatient hospital copayment (see line 12) Outpatient: 20% coinsurance (limited to a maximum payment of $3,000 per calendar year, combined with oxygen (line 23), except for prosthetic devices which are not subject to the maximum payment but do reduce the maximum payment of $3,000.
Inpatient: Included with inpatient hospital copayment (see line 12). Outpatient: 20% coinsurance (limited to a maximum payment of $3,000 per calendar year, combined with durable medical equipment (line 22).
$400 copayment per day for first five days, then 100% until discharge.
100% after $50 per visit copayment (limited to 60 visits per calendar year).
20% coinsurance (limited to 30 days per calendar year) 20% coinsurance (limited to 91 days per benefit period).
Not covered.
No dental benefits available under this plan. The state offers separate dental plans. See enrollment materials.
Not covered.
100% after $50 per visit copayment (limited to annual payment of $300).

Colorado Health Plan Description Form - PPO/EPO

	Anthem Blue Cross and Blue Shield Centennial PPO Plan	
	In-Network	Out-of-Network
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5) (For in-network, also see line 11)	BlueCares for you: a. Medical Self-Care Guide; b. BlueCares for Babies. Hearing aids, exam & fitting not subject to deductible or coinsurance (limited to maximum of $500 every 3 years combined with out-of-network). Infertility treatment 80%, subject to deductible (limited to maximum of $2,500 per calendar year combined with out-of-network). When a member desires another professional opinion, they may obtain a second surgical opinion. Includes coverage for Smoking Cessation prescription legend drugs when enrolled in an approved smoking cessation program, up to $250 per member per calendar year, $500 per lifetime.	BlueCares for you: a. Medical Self-Care Guide; b. BlueCares for Babies. Hearing aids, exam & fitting not subject to deductible or coinsurance (limited to maximum of $500 every 3 years combined with in-network). Infertility treatment 60%, subject to deductible (limited to maximum of $2,500 per calendar year combined with in-network). When a member desires another professional opinion, they may obtain a second surgical opinion.
PART C: LIMITATIONS & EXCLUSIONS		
32. PERIOD DURING WHICH PREEXISTING CONDITIONS ARE NOT COVERED [6]	Not applicable. Plan does not impose limitation periods for pre-existing conditions.	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No	No
34. HOW DOES THIS POLICY DEFINE A 'PRE-EXISTING CONDITION?"	Not Applicable.	Not Applicable.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy, a list of exclusions is available immediately upon request from your carrier. Review them to see if a service or treatment you may need is excluded from the policy.	
PART D: USING THE PLAN		
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield
39. What is the main customer service number?	303-831-2384 or 1-800-843-5621	
40. Whom do I write/call if I have a complaint or want to file a grievance? [7]	Anthem Blue Cross and Blue Shield, Complaints and Appeals 700 Broadway, Denver, CO 80273 303-831-2384 or 1-800-843-5621	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850 Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Large group policy form #96744	

Colorado Health Plan Description Form - PPO/EPO

Anthem Blue Cross and Blue Shield Liberty EPO Plan
In-Network Only (out-of-network care is not covered except as noted)
When a member desires another professional opinion, they may obtain a second surgical opinion. Includes coverage for Smoking Cessation prescription legend drugs when enrolled in an approved smoking cessation program, up to $250 per member per calendar year, $500 per lifetime.
Not applicable. Plan does not impose limitation periods for pre-existing conditions.
No
Not applicable.
Exclusions vary by policy, a list of exclusions is available immediately upon request from your carrier. Review them to see if a service or treatment you may need is excluded from the policy.
No
Yes
No
303-831-2384 or 1-800-843-5621
Anthem Blue Cross and Blue Shield, Complaints and Appeals 700 Broadway, Denver, CO 80273 303-831-2384 or 1-800-843-5621
Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850 Denver, CO 80202
Large group policy form #96744

Colorado Health Plan Description Form - PPO/EPO

	Anthem Blue Cross and Blue Shield Centennial PPO Plan	
	In-Network	Out-of-Network
PART E: COST AND MEDICAL EXPENDITURES		
43. What is the cost for this plan?	Employee Portion / State Contribution / Full Premium	
Employee only	$ 86.04 / $147.86 / $233.90	
Employee + 1 dep.	$178.04 / $220.90 / $398.94	
Employee + 2 or more dep.	$282.34 / $310.62 / $592.96	
PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT		
Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan may request answers to the questions listed below. The request may be made orally or in writing to the plan administrator and shall be answered within five (5) working days of the receipt of the request. • What are the three most frequently used methods of payment for primary care physicians? • What are the three most frequently used methods of payment for physician specialists? • What other financial incentives determine physician payment? • What percentage of total Colorado premiums are spent on health care expenses as distinct from administration and profit?	Anthem Blue Cross and Blue Shield 700 Broadway, Denver, CO 80273 303-831-2384 or 1-800-843-5621	
ENDNOTES		
1. "Network" refers to a specified group of physicians, hospital, medical clinics and other health care providers that your plan may require you to use in order to get any coverage at all under the plan, or that the plan may encourage you to use because it pays more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).	2. "Out-of-pocket maximum." The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.	3. "Emergency care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.
6. "Waiver of pre-existing condition exclusions." State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.	7. "Grievances." Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of these procedures.	

Colorado Health Plan Description Form - PPO/EPO

Anthem Blue Cross and Blue Shield Liberty EPO Plan

In-Network Only (out-of-network care is not covered except as noted)

Employee Portion	State Contribution	Full Premium
$159.42	$147.86	$307.28
$306.18	$220.90	$527.08
$474.90	$310.62	$785.52

Anthem Blue Cross and Blue Shield
700 Broadway, Denver, CO 80273
303-831-2384 or 1-800-843-5621

4. "Biologically based mental illnesses" means schizoprenia, schizo-affective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

5. "Transplants" will be covered only if they are medically necessary and the facility meets clinical standards for the procedure.

Delta Dental Plan of Colorado is the carrier for the state's dental program. The two dental plans available are BASIC and BASIC PLUS. Both plans utilize the same three choice levels of dentists. Your costs will vary depending upon the plan you select and which dental providers are utilized.

The state pays the dental premium at the "employee only" coverage level when the employee chooses the BASIC Plan. When the employee chooses the BASIC PLUS Plan at the "employee only" coverage level, the employee pays a portion of the employee only premium. For both plans, the employee pays the cost for dental coverage for eligible dependents ages five and older. Dependents under age five are covered at no premium cost for both plans.

The employee and dependents must enroll in and remain on the same dental plan for the entire plan year. A new dental plan may be selected only during the regularly scheduled annual open enrollment period.

An ID card is not required to receive dental services.

Enrolling -- Dependents Under Age Five

Even though dependents under age five are covered at no premium cost to the employee, they must be listed on the "Medical, Dental, Pretax Premium Enrollment Form" in order to receive the dental benefit. Newborns must be enrolled within 31 days of the date of birth.

Choice of Dentists

DeltaPreferred Option (DPO) is the name of the Preferred Provider Organization (PPO) offered by Delta Dental. There are three choice levels of dentists:

1. In-network DPO dentists have agreed to accept the DPO discounted fee schedule.

2. Out-of-network DeltaPremier Participating Dentists have filed usual & customary (UC) listings approved by Delta Dental and will not bill more than the UC amount. You are responsible for the difference between Delta's paid discounted fee and the UC listing amount.

3. Out-of-network Non-Participating Dentists have no agreements and have not filed usual & customery (UC) listings with Delta Dental. Therefore, if you choose a non-participating dentist, you will pay the dentist the full-billed charges and Delta Dental will reimburse you according to their DPO discounted fee schedule.

You do not have to select a particular dentist to receive dental benefits. Therefore, you have the freedom of choice of using any dentist. However, using the in-network DPO provides for lesser "out-of-pocket" costs.

Preauthorization

Preauthorization is recommended when your dentist's suggested treatment plan exceeds $400.00. Your dentist may submit a treatment plan for review by Delta before any work is actually done.

Coordination of Benefits (COB)

The state's dental plans include a coordination of benefits provision. If a state dental plan is considered a secondary plan, then it will pay the same benefits that it would have paid (had it paid first), less whatever payments were actually made by the primary dental plan (or plans) that paid first. In addition, when the state dental plan pays second, it will never pay more benefits than it would have paid for each claim, as it is submitted, had it been the primary plan that paid first.

Dental

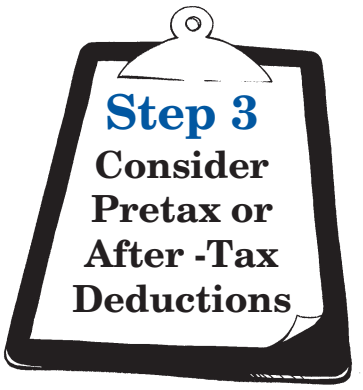
Brief Overview of the Covered Benefits Under the Dental Plans

	BASIC Plan	BASIC PLUS Plan
Calendar Year Deductible - Member/Family	$50 per member/family	$50 / $150
Calendar Year Benefit	$850	$1,200
Lifetime Ortho Benefit Maximum per Child	Benefit Not Available	$1,000

Coinsurance Percentages

	BASIC Plan			BASIC PLUS Plan		
Class I: Preventive and Diagnostic Services	**DPO In-Network**	**Participating Out-of-Network**	**Non-Participating Out-of-Network**	**DPO In-Network**	**Participating Out-of-Network**	**Non-Participating Out-of-Network**
- Routine periodic exams: two in a calendar year - Bitewing X-rays: two sets in a calendar year. - Full Mouth X-rays: one in 36 months. - Routine Cleaning: two in a calendar year. - Topical Flouride: 2 in calendary year to age 15. - Space Maintainers: to age 19. - Emergency treatment for relief of pain. - Sealants to age 15 on unrestored, noncarious permanent molars, but not more than once in any 36-month period.	100% of DPO discounted fee.	100% of DPO discounted fee. You pay difference between Delta's payment & dentist's UC fee.	100% of DPO discounted fee. You pay difference between Delta's payment & dentist's Full Billed Charges.	100% of DPO discounted fee.	100% of DPO discounted fee. You pay difference between Delta's payment & dentist's UC fee.	100% of DPO discounted fee. You pay difference between Delta's payment & dentist's Full Billed Charges.
Class II: Basic Services						
- Regular Restorative Services: Amalgam fillings, synthetic porcelain and plastic fillings (anterior teeth only). - Oral Surgery: provides for extractions (includes wisdom teeth) and other oral surgery, including pre- and post-operative care. - Periodontal Surgery: which includes periodontal cleaning (2), surgical and non-surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. - Endodontics: includes Root Canal Therapy.	50% of DPO discounted fee.	50% of DPO discounted fee. You pay coinsurance percent plus difference between Delta's payment & dentist's UC fee.	50% of DPO discounted fee. You pay coinsurance percent plus any difference between Delta's payment & dentist's Full Billed Charges.	80% of DPO discounted fee.	80% of DPO discounted fee. You pay coinsurance percent plus difference between Delta's payment & dentist's UC fee.	80% of DPO discounted fee. You pay coinsurance percent plus any difference between Delta's payment & dentist's Full Billed Charges.
Class III: Major Services						
- Cast Restoration: includes gold restorations (fillings), crowns, inlays and onlays when teeth cannot be restored with regular fillings. - Prosthodontics: dentures, partials, fixed bridges and crowns (when part of the bridge). - Prosthodontic Maintenance: bridge or denture repair, rebase or reline of dentures, recement of crowns, inlays, and onlays.	50% of DPO discounted fee.	50% of DPO discounted fee. You pay coinsurance percent plus difference between Delta's payment & dentist's UC fee.	50% of DPO discounted fee. You pay coinsurance percent plus any difference between Delta's payment & dentist's Full Billed Charges.	50% of DPO discounted fee.	50% of DPO discounted fee. You pay coinsurance percent plus difference between Delta's payment & dentist's UC fee.	50% of DPO discounted fee. You pay coinsurance percent plus any difference between Delta's payment & dentist's Full Billed Charges.
Class IV: Orthodontic Services						
- Orthodontic Services: includes the necessary procedures for the orthodontic movement of the teeth into proper alignment, position, and occulsion. Orthodontic services are available for dependent children less than 19 years of age.	Benefit not available			50% of DPO discounted fee.	50% of DPO discounted fee. You pay coinsurance percent plus difference between Delta's payment & dentist's UC fee.	50% of DPO discounted fee. You pay coinsurance percent plus any difference between Delta's payment & dentist's Full Billed Charges.

Pretax Premiums



If you elect medical and/or dental coverage, you are eligible to have these premiums deducted on a pretax basis under the premium part of the Section 125 Salary Reduction Plan. Generally, you may save anywhere from 20 to 40 percent on amounts you contribute on a pretax basis. This means your take-home pay will be greater because federal and state income taxes, your PERA contribution, and the Medicare Tax (where applicable) will be based on the lower taxable income.

How Section 125 Affects PERA Contribution

Your retirement benefits through the Public Employees Retirement Association are based on the average of your three Highest Annual Salaries (HAS). Since Section 125 premiums are not included in the salary on which PERA contributions are calculated, the monthly contribution to your PERA account is reduced. Therefore, PERA benefits will be affected by selecting pretax premiums during your three highest years, but will not be affected by selecting pretax in other years.

In review, if the salaries used to calculate your HAS are from periods in which you participated in Section 125, the PERA benefit amount paid to you will be lower than if you were not participating in the plan.

Review Your Selection Annually

Participation in pretax premiums continues automatically from year to year (except during the 2003 open enrollment), unless you cancel the pretax premium election during the regularly scheduled annual open enrollment period. Therefore, if you are within three years of retirement, take time to evaluate whether or not you should continue participation in a Section 125 plan. For more information on how Section 125 contributions affect your PERA benefits, call PERA at the phone number listed in the 2003 Benefits Rate Sheet.

Qualifying Status Changes

You can enroll in IRC Section 125 Pretax Premiums within 31 days of your date of hire, during the next regularly scheduled open enrollment period, or within 30 days of a HIPAA Special Enrollment. Once enrolled, the only time you can change your coverage level or cancel your coverage is within 30 days of the following events:

1. You or one of your dependents experience a Qualifying Status Change that causes a gain or loss in eligibility under the state's medical and/or dental plan or a similar medical and/or dental plan sponsored by the dependent's employer.

IRC Section 125 pretax premium Qualifying Status Changes are defined as follows:

- Change in your legal marital status
  - Marriage;
  - Death, divorce, annulment, or legal separation
- Change in the number of your dependents for tax purposes
  - Death of a dependent;
  - Birth or adoption, placement for adoption
- Change of employment status by you, your spouse, or any dependent that causes a gain or loss of eligibility.
  - Termination or commencement of employment;
  - A strike or lockout
  - A commencement or return from an unpaid leave of absence greater than 30 days;
  - Change from full-time or part-time status
- Dependent child becomes eligible or ineligible
  - Becomes a full-time student and meets age requirements (under age 24);
  - Marriage; military, reaches maximum age;
- Change in your residence that moves you to an area where your current coverage is not offered.

2. You experience a Significant Cost or Coverage Change, such as:
   - A significant increase in the cost of coverage under the state's plan (you must elect coverage under a similar plan);
   - A significant curtailment in the coverage (e.g., state cancels group health coverage mid-year on your plan) that affects all participants in the state's plan (you must elect coverage under a similar plan);
   - Change in coverage of spouse or dependent under the plan of the spouse or dependent's employer's Section 125 plan (either during that plan's open enrollment or due to another allowable event);
   - The addition of a new medical/dental benefit option or deletion of an existing medical/dental benefit option by the state.

3. You go on leave through the Family Medical Leave Act (FMLA).

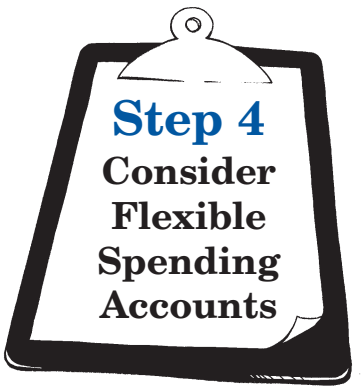
4. If you are served with a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, then you may make a change that corresponds to that judgment, decree or order.

5. You, your spouse or a dependent become eligible or ineligible for Medicare or Medicaid.

6. You, your spouse or dependent experience a COBRA "Qualifying Event."

You may only make the election change if the election change is on account of and corresponds to the status change. For example, if your spouse becomes eligible for health insurance under his/her new employer, you may drop your spouse from the state's plan if your spouse actually elects coverage provided by the new employer.

Flexible Spending Accounts



Central/ASI is the Flexible Spending Account (FSA) administrator. FSAs, governed by the Internal Revenue Code (IRS) Code 125, help you save on taxes and get more for your dollar by reimbursing you for health care and dependent day care expenses on a pretax basis. With these accounts, you can cover expenses -- such as deductibles or laser eye surgery -- that are not included in your benefit plans through the state or any other benefit plan in which you are enrolled.

With Central/ASI, reimbursements may be deposited directly into your checking or savings account or you may receive a check. With direct deposit, notices of deposit payments can be sent to you via e-mail instead of U.S. Mail. If direct deposit and/or e-mail is already set up for 2002, then you do **NOT** need to resubmit a direct deposit/e-mail form. Contact Central/ASI Customer Service to obtain more information and a direct deposit/e-mail form.

FSA Contributions May Affect PERA Benefits

FSA contributions are not included in the salary from which Public Employees Retirement Association contributions are calculated. Since PERA retirement benefits are based on the average of your three highest annual salaries (HAS), these benefits may be affected by pretax contributions.

If the salaries to be used to calculate your HAS are from periods in which you participated in a FSA, the PERA retirement benefit amount paid to you will be lower than if you were not participating in a FSA. If you are within three years of retirement, evaluate whether or not you should participate in an FSA during the years that salary will be included in the HAS calculation. For questions about FSA contributions and your PERA benefits, contact PERA.

FSA Rules and Regulations For Both Accounts

Since Flexible Spending Accounts reduce your taxes, the IRS has established certain rules that FSA participants must follow:

- Any money deposited into your Health Care FSA must be used for expenses incurred* between January 1 and December 31 and while you are a state employee. If you terminate employment, you will be reimbursed for expenses incurred through the end of the month in which your last contribution was made.
  (*Incurred is defined as the date on which services are provided, not when you are formally billed or pay the expense.)
- Any money deposited into your Dependent Day Care FSA must be used for qualifying dependent care incurred between January 1 and December 31.
- If you don't submit expenses for all the money in your account(s), you forfeit any remaining funds.
- Your decision on how much to contribute for the year remains in effect through December 31 of that year -- unless you experience a Qualifying Status Change.
- Your deposits into the Health Care FSA and the Dependent Day Care FSA must be kept separate. Money in your Health Care FSA cannot be used to pay Dependent Day Care expenses or vice versa.
- Expenses reimbursed through your Health Care FSA cannot be claimed on your tax return.
- Expenses reimbursed through your Dependent Day Care FSA cannot be claimed on your tax return or used for the federal income tax credit.
- Your reimbursement request must have a U.S. postmark of no later than April 15, 2004 when you submit the expenses incurred during Plan Year 2003. You will receive statements semi-annually to help track how much money remains in your account(s).

Health Care FSA

You can contribute up to an annual maximum of $6,000 and a monthly minimum of $10 to the Health Care FSA for calendar year 2003. If you participate in both the Health Care FSA and the Dependent Day Care FSA, the monthly minimum is $5 to each account. To confirm eligible expenses, call Central/ASI Customer Service.

Dependent Day Care FSA

The Dependent Day Care FSA can be used for reimbursement of child and/or elder day care expenses that are necessary so you and your spouse can work, actively look for work, or attend school on a full-time basis. The day care must be for children under the age of 13 or for other dependents incapable of taking care of themselves (for example, a handicapped child of any age, or a dependent parent incapable of self-care whom you claim as your dependent on your federal income tax return who lives with you at least eight hours per day). You must provide the taxpayer ID number (or Social Security number) of your day care center or babysitter. This must also be furnished with your federal tax return. If your spouse terminates employment, is not a full-time student, is not seeking employment full-time or is not disabled, you are no longer eligible to participate in the Dependent Day Care FSA and you must cancel your account.

For calendar year 2003, you can contribute up to a $5,000 annual family maximum if filing jointly; $2,500 annual individual maximum if married and filing separate income tax returns. The minimum amount you can contribute is $10 per month.

If either your income or your spouse's income is less than $5,000 a year, contributions to the Dependent Day Care FSA are limited to the amount of the lower-paid spouse's salary. If your spouse is a full-time student or is disabled, the IRS allows you to use $200 a month if you have one dependent, $400 a month if you have two or more dependents—as a basis for determining your spouse's income.

Qualifying Status Changes

See the "Flexible Spending Accounts Enrollment & Change Form" for Health Care and Dependent Day Care Qualifying Status Changes.

Disability Programs

Disability coverage helps protect a portion of your income if you are disabled due to a covered illness, pregnancy or accidental injury. The State of Colorado and the Public Employees Retirement Association (PERA) both provide state employees with disability programs. Since the state's short-term disability (STD) program is paid by the state for employees only, no enrollment is necessary. The state also offers a voluntary employee-paid long-term disability (LTD) program for employees only. The only time you can enroll in LTD is within 31 days of your date of hire or during the annual open enrollment period. PERA provides no-cost short-term disability and disability retirement and is available only if you are vested (five years of PERA covered employment).

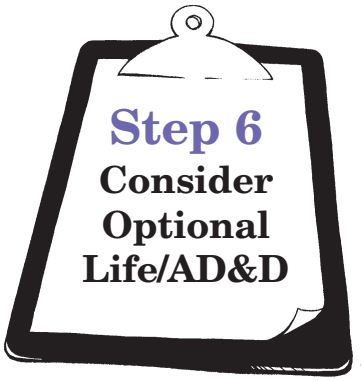
These are separate programs and you may become eligible to apply for the benefits at different times. You may apply for benefits from the state and PERA concurrently and the benefits are coordinated. Review the comparison table below. If you have any questions regarding the state and PERA plans, contact your agency payroll or personnel administrator or PERA's Customer Service Center.

Disability Programs for Plan Year 2003

	State of Colorado		PERA	
	STD	**LTD**	**STD**	**Disability Retirement**
Who is eligible?	State employees based on CRS 24-50-603(7). To purchase LTD coverage, employee must work at least 30 hours a week.		Employees who have earned 5 years of PERA service credit (state troopers, CBI agents & judges are eligible immediately.)	
Does the employer pay for the program?	Yes	No. Employees pay premium, based on age, salary & vested status.	Yes, pre-funded through monthly employer contributions to PERA.	
When does coverage begin?	From the first day of active employment.	After approval by Standard Ins. & 1st payroll deduction is taken.	Once an employee becomes vested with PERA.	
How do I apply for disability benefits?	With agency payroll/ personnel administrator within 30 days of absence.	STD claim serves as LTD application.	Request Disability Program brochure (includes application & summary plan description) from PERA's Customer Service Center.	
What is the waiting period?	30 calendar days or exhaustion of sick leave*, whichever is later.	180 calendar days from date of disability or exhaustion of all sick leave*, whichever is later.	60 calendar days or exhaustion of sick leave*, whichever is later.	None.
What is the maximum benefit period?	150 days in a consecutive 12-month period = 180 days minus the 30 calendar day waiting period.	If enrolled, benefits paid up to age 65.	The first 22 months after the payment waiting period.	Lifetime, if disability continues.
How is the disability benefit calculated?	60% of predisability earnings based on gross weekly earnings, less deductible income, prior to disability.		60% of predisability PERA-includable salary (gross pay minus Sec. 125 deductions) less deductible income.	Usually, 50% of highest average salary; but may be more or less depending upon age & service credit.
What are the maximum/minimum pay requirements?	Max: $1,500/wk less deductible income. Min: None	Max: $6,500/month less deductible income.	Calculated benefits may be reduced by certain deductible income.	None

* State rules require all sick leave must be used before disability benefits begin.

Optional Life/AD&D



Basic Life and AD&D

Anthem Life Insurance Company underwrites the state's group term life insurance program. The state provides $12,000 Basic Life and $12,000 Accidental Death & Disability (AD&D) coverage at no cost to you. Although coverage is automatic, you must complete and sign the "Life & AD&D Insurance Enrollment & Change Form" to designate beneficiaries. Submit the form directly to your agency payroll or personnel administrator unless you are also applying for optional coverage in which case you send the application directly to Anthem Life.

LIFE INSURANCE	
EMPLOYEE ***Basic Life & AD&D***	$12,000 State pays 100%
Optional Life & AD&D	Up to $300,000 in $10,000 increments Employee pays 100%
- Guaranteed Issue	$60,000 Applies to applications received within 31 days of an employee's initial eligibility, marriage, birth or adoption. All applications must include a health statement.
SPOUSE ***Optional Life & AD&D***	Up to half of the amount issued to Employee in $10,000 increments, not to exceed $150,000. Employee pays 100%
- Guaranteed Issue	$30,000 Applies to applications received within 31 days of an employee's initial eligibility, a marriage, birth or adoption. Employee Optional Life Coverage must be approved. All applications must include a health statement
CHILDREN ***Optional Life & AD&D***	*Plan 005:* infants 14 days to 6 months $500 Children 6 months to 19 years (24 if student) $5000 *Plan 010:* infants 14 days to 6 months $1000 Children 6 months to 19 years (24 if student) $10,000 Employee pays 100% Employee Optional Life Coverage must be approved. Applies to applications received within 31 days of initial eligibility, a marriage, birth or adoption or during open enrollment

Optional Employee/Spouse Life and AD&D Coverage

As an employee, you may apply for up to $300,000 of Optional Life and AD&D coverage in $10,000 increments. In the event of accidental death, your beneficiary will receive twice the face amount. If you apply for Optional Life and AD&D, you may also apply for up to half of your face amount for your spouse (the fifty percent rule). Your coverage must be approved for your spouse's coverage to be approved.

Premiums (see "2003 Benefit Rate Sheet") are based on the age of each insured and are deducted on an after-tax basis. If your spouse is also a state employee, you may elect to be covered as an employee or as a spouse of an employee, but not as both. Double coverage is not allowed.

To enroll, complete the "Life & AD&D Insurance Enrollment & Change Form" and the health statement. Place both forms together in the preaddressed envelope and mail them directly to Anthem Life. If your application is approved, Anthem Life will notify your agency payroll or personnel administrator. Coverage is effective the first day of the month following the first payroll deduction.

Guaranteed Issue

Employees who apply for Optional Life and AD&D within 31 days of date of hire, marriage, child's birth or adoption may apply for up to $60,000 ($30,000 for spouse) without evidence of insurability, subject to the fifty percent rule. Amounts up to $300,000 ($150,000 for spouse) will be considered with evidence of insurability. Approval is not guaranteed.

Optional Life/AD&D

Evidence of Insurability

If you apply for more than the guaranteed issue amount, you must provide a health statement (evidence of insurability). Use one form for both employee and spouse.

Optional Dependent Children Life & AD&D

If you apply for Optional Life & AD&D you may also apply for Optional Dependent Children Life and AD&D coverage. Eligible dependent children are covered from age 14 days to the end of the year in which they turn age 19. Full-time students up to age 24 and disabled dependent children are also eligible.

One monthly premium covers all of your eligible children for the Optional Dependent Life coverage amount you select (see "2003 Benefit Rate Sheet"). If your spouse is also a state employee, only one of you may apply for coverage for your children. Double coverage is not allowed.

To enroll, complete the Life & AD&D Insurance Enrollment and Change Form. Submit the form directly to Anthem Life. You may apply for Optional Dependent Children Life & AD&D coverage when first eligible or at open enrollment. You may also apply for Optional Dependent Children Life & AD&D within 31 days of a marriage, birth or adoption. A health statement is not required.

Description of Plan Benefits

The Basic Life and AD&D Insurance Description of Plan Benefits booklet is included with your enrollment packet. If you enroll in the Optional Life & AD&D coverage, Anthem Life will send the Optional Life Description of Plan Benefits booklet directly to your home address.

How to Change Your Beneficiary

You may change your beneficiary at any time by completing a new Life & AD&D Enrollment & Change Form with the changed beneficiary designation. Submit the signed and dated form to your agency payroll or personnel administrator, NOT to Anthem Life. All enrollment forms are maintained at your agency payroll or personnel administrator's office.

Conversion Benefit

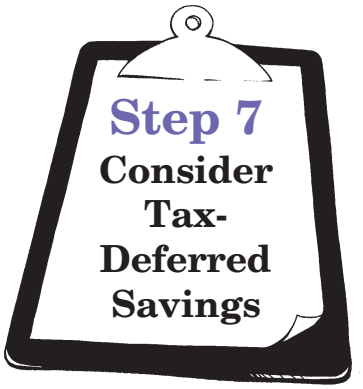
Upon termination of employment, you and your covered dependents may convert all or part of your Basic Life and Optional Life coverage to an individual whole life policy. There is no conversion benefit for AD&D. To qualify for the conversion, you must apply within 31 days of your termination of coverage. A conversion application form is available by contacting Anthem Life Insurance Company at 800-760-1312. Return the completed form to Anthem Life for processing.

Waiver of Premium

If you become totally disabled, you may be eligible for waiver of premium. Call Employee Benefits for additional information and to request an application for waiver of premium. Return the completed form to Anthem Life for processing.

Canceling Coverage

You may cancel Optional Life coverage at any time by submitting a Life & AD&D Enrollment & Change Form. Your coverage will terminate the last day of the month following the final payroll deduction. You must cancel spousal coverage within 31 days of a final divorce. Coverage for dependent children must be cancelled within 31 days of the date your last child becomes ineligible. Submit the completed and signed form to your agency payroll or personnel administrator, NOT to Anthem Life.



The Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) provided many new advantages for employees to contribute to the State 457 Deferred Compensation Plan, PERA's 401(k) Plan, and the 403(b) Tax Deferred Annuity (TDA) Program (offered through some state higher education institutions). These plans (review the chart on the following page) give state employees easy, hassle-free ways to supplement their retirement income. Because deductions are taken from your pay before taxes are calculated, the tax deferred compensations plans have already saved you some money. More importantly, they offer you several advantages over the traditional types of savings mentioned.

Contribution Coordination

Due to EGTRRA, contribution limits have changed for 2003. There is no longer a coordination between the 457 and the 401(k) or between the 457 and the 403(b), and since the contribution limits have increased, you can contribute more:

457 + 401(k) = $12,000 + $12,000 = $24,000
457 + 403(b) = $12,000 + $12,000 = $24,000
401(k) + 403(b) = $12,000 (still coordinated; may be further limited by your salary base.)

PERA Matchmaker Program

PERA members who contribute to voluntary defined contribution plans in calendar year 2003 will receive a dollar-for-dollar match on their contribution of up to two percent of their PERA-includible salary (gross income minus IRC Section 125 and Transportation Equity Act deductions) for state employees as a result of the PERA Matchmaker Program. This program provides for the employer to use the contributions that it otherwise would send to PERA for the match in years that PERA is fully funded.

PERA members who participate in PERA's 401(k) Plan, the state's 457 Deferred Compensation Plan, or a 403(b) plan will receive the match. No maximum dollar amount was set for the match, although the normal IRS limits must be met for the various plans. The match is made each pay period that a member contributes to a tax-deferred plan and PERA.

401(a) Defined Contribution Pension Plan For Elected and Appointed Officials

In January 1999, an alternative pensionplan was introduced for appointed and elected officials who would not noarmally meet the five year vesting status with PERA.

For those approximately 500 eligible employees (Executive Directors, Governor's office, Legislators) choosing this option, is a one-time irrevocable election made within 31 days of hire or during January of each year.

For more information, visit the Division of Human Resources website a www.state.co.us/dhr/ under tax-deferred savings plans or contact Employee Benefits at the phone number listed in the 2003 Benefits Premium card.

State of Colorado Comparison of Plan Characteristics for 2003

	State 457	State 401(a) Match Plus	PERA 401(k)	403(b)
Eligibility	Any state employee	Automatic if enrolled in 457 Plan	Contributing PERA member	Employees of higher ed.
When to Enroll	Any time	Any time	Any time	Any time
Minimum Contribution	$25 per month	Varies, depending on your 457 contribution	None	Contact plan administrator
Maximum Contribution	$12,000 in 2003 $13,000 in 2004 $14,000 in 2005 $15,000 in 2006 then indexed in $500 increments	Up to 2% of PERA includible compensation	$12,000 in 2003 $13,000 in 2004 $14,000 in 2005 $15,000 in 2006 then indexed in $500 increments	$12,000 in 2003 $13,000 in 2004 $14,000 in 2005 $15,000 in 2006 then indexed in $500 increments
Catch-up Provision	For the 3 consecutive years prior to retirement you can contribute up to twice the available limit	Not available	Not available	With 15 years of service, you may contribute up to $13,000 for 3 consecutive years
Catch-up for participants age 50 & over	Participants age 50 & over may make additional contributions of $2,000 in 2003 increased by $1,000 each year to $5,000 in 2006, then indexed in $500 increments[1]	Not available	Participants age 50 & over may make additional contributions of $2,000 in 2003 increased by $1,000 each year to $5,000 in 2006, then indexed in $500 increments[1]	Participants age 50 & over may make additional contributions of $2,000 in 2003 increased by $1,000 each year to $5,000 in 2006, then indexed in $500 increments[1]
Loans	Not available	Not available	Up to 3 loans at any time for any reason	May be possible; contact plan administrator
Distributions	Separation from service, retirement, disability, deminimus	Retirement, disability, separation from service[2]	Age 59[1/2], retirement, disability, separation from service[2]	Age 59[1/2], retirement, disability, separation from service[2]
Active Service Withdrawal	Unforeseeable emergency	Unforeseeable emergency	Financial hardship or after age 59[1/2]	Financial hardship or after age 59[1/2]
Purchase Service Credit	Yes	Yes	Yes	Yes
Rollover Provisions	Rollovers between 457, 401(k), 403(b), IRA[3]	Rollovers between 457, 401(k), 403(b), IRA[3]	Rollovers between 457, 401(k), 403(b), IRA[3]	Rollovers between 457, 401(k), 403(b), IRA[3]
Penalty on early withdrawals before age 59-1/2	No	Yes, unless rolled over to another tax-deferred account, lifetime monthly payments, or an exception applies	Yes, unless rolled over to another tax-deferred account, lifetime monthly payments, or an exception applies	Yes, unless rolled over to another tax-deferred account, lifetime monthly payments, or an exception applies
Plan Fees	Fund operating expenses; $9 annual fee assessed quarterly ($2.25); no fees for new participants until July 2003	Fund operating expenses	Investment management fees; $18 annual fee assessed monthly ($1.50); new participants pay $12 annual fee assessed monthly ($1.00)	Contact plan administrator
Commission, load, or payout fees	None	None	None	Contact plan administrator
Access to Plan	www.colorado457.com	www.colorado457.com	www.copera.org	Contact plan administrator

1 This catch-up contribution provision may not be used at the same time as the traditional 457 catch-up contribution provision.
2 All withdrawals are subject to ordinary income tax. A 10% federal tax penalty may apply to withdrawals made prior to age 59-1/2.
3 Any monies rolled over from a 457 to any other plan may be subject to the 10% federal tax penalty may apply to withdrawals made prior to age 59-1/2.

Eligibility & Enrollment

Who is eligible?

State employees and their eligible dependents may receive group benefits as prescribed in the Colorado Revised Statutes 24-50-601 through 24-50-615 and the State Benefits Plans section of the State Personnel Director's Administrative Procedures. "Employee" does not include persons employed on a temporary basis. Individuals not meeting these requirements are not eligible to enroll in or be enrolled in any state group benefit plan.

"Dependent" means an employee's legal spouse; each unmarried child, including natural children, adopted children, stepchildren, and foster children. Children are eligible through the end of the calendar year in which the child turns 19 years of age, for whom the employee is the major source of financial support or for whom the employee is directed by court order to provide coverage; each unmarried child 19 years of age through the end of the calendar year in which that child is no longer a full-time student in an educational or vocational institution, but no longer through the end of the month in which the full-time student turns 24 years of age, and for whom the employee is the major source of financial support or for whom the employee is directed by court order to provide coverage; or an unmarried child of any age who has either a physical or mental disability, as defined by the carrier, not covered under other government programs, and for whom the employee is a major source of financial support or for whom the employee is directed by court order to provide coverage.

When can I enroll?

To be covered under any state group benefit plan, employees must enroll within 31 days of their hire date or during the annual open enrollment period.

To be covered under a state group medical, dental, and optional life insurance plan, eligible dependents must be enrolled within the same time frames that employees may enroll or within 31 days of an "eligible event."

The "eligible events" for enrolling dependents are:

- Marriage
- Birth
- Child placed for adoption
- Child returning to full-time student status
- Court decree requiring dependent coverage as specified in Title 14
- Placement of foster child
- Legal custody/guardianship of a child
- Child loses eligibility for Medicaid coverage
- Birth of a grandchild when parent is still an eligible covered dependent
- Unmarried child of any age who is medically certified as disabled by the carrier and dependent upon the employee as the major source of financial support no matter when the disability occurred.

Dependents are not eligible for enrollment in Basic Life/AD&D Insurance, Flexible Spending Accounts, Long-Term Disability, or Tax Deferred Savings Plans.

Leaving State Employment; COBRA

If you are enrolled in one or more of the state's group benefit plans and you are terminating state employment, you may want to consider continuing coverage:

- COBRA Medical
- COBRA Dental
- COBRA Health Care Flexible Spending Account
- Conversion of Group Life Insurance

If you are terminating employment due to a disability, benefits may continue based on certain circumstances, subject to policy requirement:

- COBRA Disability extension for Medical and Dental
- COBRA Health Care Flexible Spending Account
- Group Life Insurance Waiver of Premium

COBRA is a federal regulation that allows continuation of medical, dental and Health Care Flexible Spending Account benefits. Group health coverage continued through COBRA shall be the same as coverage offered to eligible active state employees and dependents.

Group Life Insurance may be converted to an individual whole life policy and under certain circumstances, premiums may be waived for Group Life Insurance.

For more information about COBRA, Conversion of Life Insurance or Life Insurance Waiver of Premium, see the Certificate of Coverage provided by the insurance carrier. You may also contact your agency payroll or personnel administrator or call the Department of Personnel & Administration, Employee Benefits at 1-800-719-3434 or 303-866-3434.

Frequently Asked Questions & Answers

Q: What is an EPO (the Anthem Liberty EPO is new for 2003)?

A: An EPO is an Exclusive Provider Organization that is similar to an HMO in that it incorporates co-payments and does not provide any coverage for out of network providers.

Q: Why are the AETNA and CIGNA plans no longer available to state employees?

A: Aetna informed the State that they could not sustain the heavy financial losses that began in 2001 and continued into 2002. Therefore, they declined to renew their plan for the 2003 plan year.

CIGNA informed the State they would only continue the contract with unblended rates for Pueblo County -- in other words, charge a higher premium to Pueblo County than is charged to the other counties. DPA has committed to State employees that it will not allow a carrier to charge more to some State employees than they charge other State employees. Therefore, the State will not offer CIGNA in 2003.

Q: These "plan redesigns" really mean higher co-payments or deductibles and reduced benefits. Why do I keep paying more for less?

A: One of the major components of the State's health care increases is utilization, the number of times each of us goes to the doctor, gets a prescription, and/or receives a specific medical procedure. There are very few ways to reduce the overall premium increases of fully insured health plans in the current marketplace. One way of reducing the 22 - 78% increases that the State and its employees faced during the rate renewal process was to redesign plans. Without these plan redesigns rates would be much higher.

Q: What can I do if I simply cannot afford any of these plans?

A: The DPA Benefits Unit has gathered a list of options for uninsured State of Colorado employees and dependents. Please consult your department's benefits administrator for more information about these options.

Q: I've seen lots of advertisements about good individual health plans with lower premiums. What about individual health care coverage?

A: Individual health plans are a viable option for many individuals, particularly those who are self-employed. However, when considering your health insurance options, it is very important to familiarize yourself with all aspects of the plan. Often plans with lower premiums have extremely high deductibles and require additional payments for benefits not included in the base plan. Not all plans include coverage for emergency care, ambulance service, pregnancy, long-term care, and more. Individual coverage requires an initial health risk assessment, which could result in the denial of coverage or an exception for pre-existing conditions. Be sure to consider all these factors to help ensure that an individual health plan can meet the needs of you and your family.

Q: What is the $10 Self-Funding Assessment?

A: The self-funding assessment will help enable the State as an employer to return to self-funding medical insurance plans for its employees. As DPA Executive Director Troy Eid has said at town hall meetings, the assessment will make it happen "sooner rather than later." While some may not agree with this choice or the assessment itself, DPA has made the decision to do something, and not simply sit and watch rates skyrocket year after year.

Q: How will self funding help costs?

A: Self-funding alone may not reduce future premiums, but it may help the State control future premium increases by potentially reducing overhead or administrative costs currently charged for fully insured plans. Self-insuring will also enable the State to design more innovative plans that can be offered statewide, as opposed to fully insured programs that may only be licensed to do business in certain counties.

Q: Who has to pay the assessment?

A: Starting January 1, 2003, employees enrolled in a State medical plan will have $10 per month added to their portion of the premium to help return the state to self-funding.

Q: Why do I have to pay if I'm retiring in the next few years?

A: All employees have the ability to enroll or not enroll in one of the State's medical insurance plans each year. Any employee or his or her dependents could have a large number of claims in one year and then leave the plan. The increased premium caused by increased utilization is borne by those that remain in the plan. We have no way of knowing how many employees will be in the plan from one year to the next. The pool of dollars that will be collected will allow all benefit eligible employees to participate in the self-funded program, not just those who have paid into it. Though this may not seem fair, it is the only way to collect a pool of dollars that will help return the State to self-funding.

Q: Then, why aren't all benefit eligible employees being required to pay this $10 assessment instead of only those that are currently enrolled?

A: We are in the process of reviewing our ability to charge all benefit eligible employees. Depending upon the results of this review, the State may look to legislative action to require this assessment to be paid by all benefit eligible employees.

Q: How can you ensure that the money will only be used for self-funding?

A: The State is reviewing legislative action to protect the money collected through the monthly self-funding assessment. Such action may help assure that this money is expressly used to finance a self-funded medical plan.

Q: What is the $2.90 State Administration Fee?

A: Both the State's Employee Benefits Unit and the Colorado State Employees Assistance Program (CSEAP) are cash funded. Both of these programs' funding is charged to employees who are enrolled in the State's medical plans to cover their administrative budgets. Similarly, the Division of Motor Vehicles is cash funded and collects fees through licenses.

Definitions

Annual Out-of-Pocket Maximum
Maximum amount each member pays for medical expenses in any one plan year, excluding deductibles, copayments, prescription drugs, certain behavioral health expenses, amounts above usual, customary and reasonable (UCR) charges and ineligible expenses. An annual family maximum is the total amount of combined medical expenses a family pays in any one calendar year.

Coinsurance
Percentage of eligible expenses the plan pays and percentage of eligible expenses you pay, after satisfying deductibles; e.g., 80/20 means the plan pays 80 percent of eligible expenses and the you pay the remaining 20 percent.

Coordination of Benefits (COB)
Method of integrating benefits payable under more than one medical/dental plan.

Covered Services
The services and supplies that have been determined to be benefits under the terms of each plan's additional communications materials.

Deductible
Amount of certain eligible expenses that must be paid in any one calendar year before a plan pays a benefit.

Eligible Expense(s)
As defined by IRS Publication 502 for Health Care Flexible Spending Accounts, "medical care expenses include amounts paid for the diagnosis, care, mitigation, treatment, or prevention of disease, or for treatments affecting any part or function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness."

Emergency
A serious accident, sudden illness, or any condition which, if not treated **immediately**, might result in a long-term medical problem or loss of limb or life. (Also see your medical plan's additional communications materials.)

Evidence of Coverage
Evidence of Coverage explains the benefits, limitations, exclusions, terms and conditions of coverage of your selected plan(s).

Formulary or Preferred Drug List
A list which identifies which drugs a physician may prescribe, thereby allowing a patient to pay a lower copayment than drugs that are not on the formulary.

Full-Time Student Status
The student must be attending class for 12 credit hours or more or the equivalency of full-time student status based on criteria established by the school, facility, or institution.

Health Maintenance Organization (HMO)
Managed health care delivery system serving specific geographic areas. Requires a small copayment for each covered service; plan pays the remaining expense of the covered service. You must use the doctors and facilities within the HMO network to receive benefits.

Out-of-Network Providers
Any provider (e.g., doctors, specialists, dentists, hospitals) not under contract to a managed care system.

Preferred Provider Organization (PPO)
A PPO is based on the same principle as a fee for service plan, whereas each member is encouraged to use "preferred providers" contracted with the plan at a pre-arranged fee schedule.

Prescription Drug Formularies
A **"prescription drug formulary"** is a drug listing that has been determined by each medical plan to be safe and cost effective. Each medical plan's pharmacy team creates a formulary by selecting generic and brand name medications that have been proven to be medically effective.

Preventive Care
Services done for early detection of illnesses or abnormalities that do not have noticeable symptoms, and to prevent illnesses or other medical conditions (e.g., routine physicals, immunizations).

Primary Care Physician (PCP)
A doctor within the network who acts as the first contact for medical care, treats a majority of health care problems, provides referrals to specialists as necessary, and coordinates care within the network.

Referral
Written authorization from your Primary Care Physician to visit a specialist or specialty.

Short-Term Disability (STD)
Plan which protects employee's income while disabled due to illness, pregnancy, or certified disability. Maximum benefit period is 180 days less the waiting period.

Tiered Formulary
A tiered formulary helps minimize out-of-pocket expenses and encourages the use of generics when appropriate. Tiered formulary copayments vary depending upon whether generic or brand name drugs are prescribed.

Usual, Customary, and Reasonable (UCR)
Charges for services and/or supplies essential to your care that are no more than the amount normally charged by most providers in the area.

Urgent Care
A condition that requires **prompt** medical attention, but is not immediately life- or limb-threatening. Symptoms occur unexpectedly and are severe; it is apparent that delaying treatment may escalate the condition or cause serious medical problems. See your medical plan's additional communications materials for more information about urgent situations.

Important Contact Information

Medical Plans
Anthem Blue & Cross Blue Shield Centennial PPO/Liberty EPO..... 303-831-2384
1-800-843-5621
Kaiser Permanente HMO..... 303-338-3800
1-800-632-9700
PacifiCare HMO..... 1-800-877-9777
Rocky Mountain Health Plans HMO..... 970-243-7050
1-800-346-4643
San Luis Valley HMO..... 719-589-3696
1-800-475-8466

Dental Plans
Delta Dental..... 1-800-489-1768

Medical Quest
Medical & Dental Provider Listings..... www.medicalquest.com/costate

Flexible Spending Accounts (FSAs)
Central/ASI Customer Service..... 1-800-659-3035
Automated Acct. Balances & Reimbursements InfoLine 125..... 1-800-366-4827
www.asiflex.com

Life Insurance Plans
Anthem Life: General Information & Enrollment Processing..... 1-800-760-1312

Disability Plan
Standard Insurance Co. - General Information..... 303-759-8702, Ext. 60
1-800-759-8702, Ext. 60
Standard Insurance Co. - Claims..... 1-800-252-5577

Tax Deferred Savings Plans
457 Deferred Compensation Plan - Great-West/BenefitsCorp..... 1-800-838-0457
www.colorado457.com

401(k) Plan - PERA..... 303-832-9550
1-800-759-7372
www.copera.org
403(b) Annuity Plan..... Contact Campus Benefits Office

Retirement Plan
PERA..... 303-832-9550
1-800-759-7372
www.copera.org

401(a) Defined Contribution Pension Plan for Elected & Appointed Officials
General Information - Employee Benefits..... 303-866-3434
1-800-719-3434
ICMA-RC Vantage Line..... 1-800-669-7400
VALIC..... 1-800-448-2542

Colorado State Employee Assistance Program
CSEAP..... 303-866-4314
1-800-821-8154

Employee Benefits
Department of Personnel & Administration
Division of Human Resources - Metro Denver 303-866-3434
1-800-719-3434
www.state.co.us/dhr/